Reversing the HIV Epidemic Through Sound Public Health Policy

Presented at online meeting, 3/9/21

To:
Carl Schmid and John Wiesman, Co-Chairs
Presidential Advisory Council on HIV/AIDS (PACHA)
Current PACHA Membership and Staff, including Kaye Hayes, Caroline Talev

From:
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On behalf of the Beyond AIDS Foundation, I wish to express appreciation for the opportunity to submit input at the March 2021 PACHA meeting, to briefly discuss the proposals below. I hope this will include an opportunity to interact with the Council members orally or by video (virtually).

I am enclosing, and attaching to the cover email, some of the Foundation's major current recommendations. We are not strangers to PACHA. The leadership of the Beyond AIDS Foundation includes two Board members who are former PACHA members, Franklyn Judson of Denver and Monica Sweeney of New York City. I have also delivered past testimony to PACHA in person.

We are pleased that PACHA is especially interested in meaningful actions to implement the National HIV/AIDS Strategy (NHAS), the goal of ending the HIV epidemic in the U.S., and fulfillment of the Executive Order on Advancing Racial Equity and Support for Underserved Communities. Our recommendations are particularly addressed toward improving implementation of the NHAS, especially for more effective and integrated HIV/AIDS prevention, and will contribute also toward the other goals.

These recommendations have implications for future grants from CDC and HRSA, for accountability regarding fulfillment of grant conditions, and for programs that do not yet exist in either agency (such as federal subsidies for PrEP and training of primary care providers to initiate HIV treatment). They also could help guide the development of national HIV/AIDS prevention policy and contribute to the HIV/AIDS eradication program. In our judgement, most of our recommendations can probably be implemented without significantly increased federal funding, by re-directng some funds. However, as mentioned below, we also recommend more efforts to raise state, local, and private sector prevention funding to supplement federal resources (while recognizing the current impediments during the pandemic).

Most of the proposals below were also submitted for consideration as revisions to the latest draft for the (NHAS), see attached. We have also notified NASTAD, and are inquiring about the potential of discussing them with CHAC. Many of our recommendations are based on the **attached survey of state and territorial HIV/AIDS Directors, published in AIDS Education and Prevention in 2019**, including its **conclusions/recommendations**. That survey revealed significant inconsistencies in policy and practice among the states and territories, and what we considered to be deficiencies in many jurisdictions. **I have**

copied and pasted at the bottom of this message the response of Dr. Jonathan Mermin to our input to the NHAS and to the list of proposals having to do with CDC specifically.

Our most important recommendations include:

- That CDC and HRSA, in their RFPs, request more individualized grant applications for HIV prevention and treatment, addressing specific goals and in particular weaknesses and deficiencies of each state/territory/city's HIV/AIDS program, and new policy directions from CDC and HRSA that have not yet been implemented by the respective jurisdictions. The grant recipients should have an opportunity to negotiate with CDC regarding these goals, and then should be accountable for doing their best to achieve them. Any goals that are not reached during a funding period should be emphasized even more specifically in the next renewal grants.

- That CDC goals increasingly stress the need for more standardized outreach to newly diagnosed patients and their providers (if any). If diagnosed persons are not linked to immediate treatment, and if partner services are not done, an early deficiency in the HIV Care Continuum results. Minimum purposes should be to help assure the most rapid possible linkage to and initiation of care, partner services, and referrals for other services as indicated. This need not be absolute uniformity, as we found eight jurisdictions that reported admirable patient outreach "extras" such as screening for substance abuse and mental illness, answering patient questions on disease course or managing acute HIV, ADAP, social services, and assistance in obtaining health insurance. It should remain possible for jurisdictions to continue to fund these out of CDC grants. We are more concerned about the 36% of states and territories that did not routinely attempt to contact either all reported patients or all providers when those existed. Sometimes, in some locations, the main purpose in contacting providers or patients is to complete reporting forms, rather than to assist in overall public health goals.

- That CDC recommend new directions for HIV surveillance (expansion of "data to care") to help monitor and facilitate patient progression along the HIV Care Continuum; and that RFPs indicate that part of the money is to be spent on these activities. As a specific example, **many but most states were already tracking MISSED viral load results in diagnosed and reported patients, and we recommend that this become a national expectation.** Such testing can promote retention in care. Previously diagnosed patients for whom viral load results have not been received in the past year should have outreach to determine whether they never entered or have dropped out of care (in which case renewed linkage efforts should be implemented), have moved to other jurisdictions (in which case those jurisdictions should be informed), or whether some laboratories are not complying with reporting requirements (in which case jurisdictions should intensify work with those labs). HRSA should meanwhile strongly emphasize the need for monitoring of viral load (as well as CD4 counts) in care funded by Ryan White.

- That HRSA grant recipients, including clinics receiving Ryan White funds, be expected to follow-up on missed appointments, so as to increase treatment retention as part of the HIV/AIDS Care Continuum.

- That monitoring of genotype results become universal and an activity for which federal money can be used, with results forwarded to CDC for analysis and detection of emerging viral resistance throughout the country to current medications. Currently, this type of surveillance depends on

supplemental grants, and is therefore somewhat sporadic, with geographic gaps. Progress in this direction should include encouraging states that are not yet receiving genotype results to work to assure that genotypes be considered as HIV results and thus reportable to public health. The less-commonly performed phenotypes could be added to this program. HRSA's Ryan White program guidelines should meanwhile emphasize the appropriate indications for genotype testing.

- That all jurisdictions, and particularly states, be encouraged, and incentivized (perhaps by making part of the grants be matching funds), to designate some of their own money for HIV prevention, so as to supplement CDC grants. Currently, New York state requires all counties to raise HIV prevention funds and adds a hefty state contribution, but many states have no funds to spend other than their CDC grants. (As promised, the published article does not identify any states or territories by name, but if requested, we can supply a spreadsheet with the survey results identifying responses by jurisdiction; this was already shared with CDC and NASTAD.) We are aware that the COVID-19 pandemic has severely strained state and local resources, without a federal bail-out so far. This makes outreach to the private sector, as done in several jurisdiction, worth considering.

- That the NHAS, as well as the viral hepatitis strategy and the pending new STD strategy, all aim to better coordinate prevention efforts for HIV with other diseases included in specifically other STDs and viral hepatitis. This could begin with more joint screening efforts, and more joint health education about safer sex and avoidance of needle sharing. As we promote PrEP, we should not omit urging condoms, counseling, and frequent screening as indicated, to prevent not only HIV infections, but a whole range of other sexually-transmitted infections.

- That both CDC and HRSA prevention and treatment grants include requirements to address the systemic barriers that communities face in order to achieve the goals of advancing racial equity and support for underserved communities.

- That a way be determined to cover PrEP for uninsured patients. The recent USPSTF recommendation for PrEP should increase insurance coverage, but for those without any, it will not help. Ryan White funds are currently restricted by law to be used only for care of HIV-positive persons. Should a change in the statute by recommended, or can a special category of grants be established by either HRSA or CDC? This is a topic on which we corresponded with Dr. Stoner in 2019.

- That training be made available nationwide to primary care providers on the baseline tests and HHS-recommended starting medications for treatment-naive patients indicated to initiate HIV treatment, without a wait for an infectious disease referral, and without the need to wait for the test results. I have personally provided this training to resident physicians at Loma Linda University, in as little as a 1-hour session. Both short and longer slide presentations are posted on our Foundation's Web site, at **http://www.beyondaids.org/resources.html.**

Tuesday, December 29, 2020, 10:56 am

Dr. Hattis:

Thank you for the thoughtful input on the new NHAS from the Beyond AIDS Foundation, and for your encouraging comments on our new DHAP leadership. Even in the midst of COVID-19, I believe we will see progress in HIV over the next year.

All the best,

Jono

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